INTRAUTERINE CONTRACEPTIVE (IUC) COMPLICATIONS

DEFINITION	IUC complications include but are not limited to perforation, missing threads and/or thread problems, delayed menses, complicated pregnancy, cramping and pelvic pain, abnormal bleeding, expulsion, and symptomatic actinomycosis noted on Pap screening. Complications may be treatable or may require removal of device.
SUBJECTIVE	May include: 1. No symptoms. 2. LMP. 3. Medical, sexual, and contraceptive use history, initial or update, as appropriate. 4. History of any method related problems, including but not limited to: a. intense cramping and/or pelvic pain. b. thread problems. c. abnormal vaginal bleeding or discharge. d. concern of IUC expulsion. e. symptoms of anemia (pallor, fatigue, palpitations).
OBJECTIVE	May include: 1. Visualization of cervix to note a. presence or absence of bleeding/discharge. b. presence or absence of threads. c. color and number of threads and length of threads, if present. 2. Pelvic examination to note a. palpation of os for IUC presence. b. uterine sizing if suspected pregnancy. Must exclude: 1. adnexal tenderness or masses (suspect ectopic pregnancy). 2. PID
LABORATORY	May include: 1. Sensitive urine pregnancy test. 2. Vaginitis/cervicitis testing as indicated. 3. Hemoglobin. 4. Pap result reporting actinomycosis presence with evidence of infection.
ASSESSMENT	Complications related to IUC use.

PLAN

Treatment may be provided according to identified problems.

1. Thread Problems - **Non Pregnant**. If the IUC threads are missing, it may mean the client has expelled the IUC, the threads have wrapped around the IUC, has ascended into the uterine cavity, or that the IUC has perforated the uterus. Foreign countries may completely cut IUC threads at time of insertion.
   a. Endocervical threads may be extracted by rotating a cyto brush in the canal. Withdraw threads, if able. Note length. IUC may remain in place if client desires or remove IUC per protocol if client desires.
   b. Examine cervix with uterine sound, sterile Q-tip, revisualize canal through endeocervial speculum. If IUC in endocervix remove and offer to replace.
   c. If expulsion suspected obtain ultrasound or x-ray to determine IUC absence or presence and location.
   d. If IUC is absent, provide ECPs if appropriate, and/or another form of contraception.
   e. If threads missing, but IUC present in uterus and client desires removal, refer to MD.
2. **Pregnant:** Pregnancy of any kind is rare with an IUC in place. However, if a woman becomes pregnant with an IUC in place, confirm that the pregnancy is intrauterine and not ectopic. Remove the device promptly, regardless of her plans for the pregnancy. Early removal reduces the risk of spontaneous miscarriage, preterm delivery, or septic spontaneous abortion. An IUC left in place during pregnancy carries no known risk of teratogenesis. If pregnant, consider a timely referral to a physician for removal of the IUC.
   a. Discuss pregnancy options and refer for appropriate care.
   b. If the woman plans to have an induced abortion, remove the device promptly rather than wait for removal at the time of abortion to reduce removal complications.
   c. If client refuses IUD removal, the following should be documented in her chart: Client informed of increased risk of spontaneous abortion, premature labor, and septic infection because of an IUC. Client chooses to not have IUC removed and accepts the increased risks that have been explained to her. Refer to MD.
3. Delayed Menses - Non Pregnant. An IUC user who complains of delayed menses (no vaginal bleeding at the expected interval) may not be pregnant. Delayed or absent menses common with levonorgestrel IUC's.
   a. Check for IUC threads.
   b. If LMP less than 2 months ago or more than her usual interval, reassure her and urge her to return in 2 weeks for repeat pregnancy test.
4. Cramping and pelvic pain. Women with IUC who experience cramping and pelvic pain should be evaluated to rule out perforation, pregnancy, PID, threatened or partial expulsion, dislodgement or expulsion.
   a. Acute uterine perforation, either by the uterine sound or IUC, during insertion may result in a medical emergency. Non-acute uterine perforation may occur at any time and is most frequently detected by imaging studies in clients with missing IUC-threads**.** If perforation has been confirmed or is suspected, refer for evaluation and removal.
   b. Any client with ectopic pregnancy must be referred for STAT MD evaluation.
   c. Any client with suspected or symptomatic PID, refer to PID protocol (RD 9). See infection with IUC also.
   d. Offer NSAIDS with menses or just before menses every month to reduce cramping.
5. Abnormal Bleeding or IUC Expulsion - Non-Pregnant. Women using a copper IUC may find their menses become heavier, longer, more uncomfortable, particularly in the first several cycles of copper IUC use. Partial IUC expulsion often presents with acute vaginal bleeding. The client needs to be evaluated to exclude other sources of bleeding. Decision about management depends upon the client's clinical status and her preferences.
   a. If the IUC expelling:
      1) Remove the IUC.

PLAN (cont)	2) If not pregnant, may re-insert 3) If complete expulsion suspected and client does not know if IUC came out or not, confirm by abdominal x-ray or ultrasound. b. For other abnormal bleeding or anemia: 1) For post-coital bleeding: check for cervical infection or polyps. 2) For spotting/hypermenorrhea: a) Offer NSAIDS to start at onset of each menses to reduce menstrual blood loss (Ibuprofen, 400-800 mg q 4-6 hrs. PO x 3 days). b) Instruct client to keep menstrual calendar for 2 cycles. c) Consider rule out infection and/or pregnancy. c. Treat anemia per protocol. d. For clients not satisfied with method or not responding to above plan, offer to remove the IUC (see IUC Removal Protocol). 7. Infection with IUC use: a. BV or candidiasis: treat routinely. b. Trichomoniasis: treat and reassess IUC candidacy. c. Cervicitis or PID: IUC removal not necessary unless no improvement after antibiotic treatment. However, if IUC determined to be removed, give first dose of antibiotics to achieve adequate serum levels before removing IUC. 8. Actinomycosis - With IUC. An asymptomatic IUC user who has "Actinomyces-like organisms" reported on Pap smear is a common finding of limited clinical significance. If symptomatic, the device should be removed and a course of oral antibiotics given. Pelvic actinomycosis is a very rare, serious, and poorly understood infection. 9. Treat with antibiotic for 30 days and have patient return in 48-72 hours to evaluate response to treatment. Refer to MD if no improvement. a. Penicillin G 500 mg orally 4 times a day for 30 days b. Tetracycline 500 mg orally 4 times a day for 30 days (contraindicated if pregnant or breast feeding). c. Doxycycline 100 mg orally 2 times a day for 30 days d. Amoxicillin/clavulanate 500 mg orally 2 times a day for 30 days. 10. If partner can feel IUC threads during intercourse: a. Explain this can happen if threads are cut too short. b. Can cut threads shorter so they are not coming out of cervical canal. c. Too long: need to check for partial expulsion. If in place, then trim.
CLIENT EDUCATION	1. Reinforce IUC education if client chooses to continue method or plans insertion of another. 2. Review safer sex education, if appropriate. 3. Advise of pertinent client information regarding antibiotic use. 4. Counsel client on choosing another method of birth control if IUC is removed and client does not desire pregnancy. (Refer to chosen method protocol.) 5. Recommend that client RTC annually and PRN for problems.
CONSULT / REFER TO PHYSICIAN	1. Any client with signs and symptoms of perforation. 2. Suspected ectopic pregnancy (STAT referral). 3. Pregnant clients with IUC in place. 4. Client with persistent bleeding or infection symptoms not resolved after treatment. 5. Any client who, by protocol, should have IUC removed but refuses.

	6. Any difficult IUC removal. 7. Any client needing ultrasound or abdominal flat plate.

IUD WARNING SIGNS

P	•	Period late (pregnancy), abnormal spotting or bleeding
A	•	Abdominal pain, pain with intercourse or urination
I	•	Infection exposure (any STD), abnormal discharge
N	•	Not feeling well, fever, chills, nausea/vomiting
S	•	String missing, shorter or longer

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References:

1. Hatcher, R.A., Trussell, J, Nelson, A. L., et al. ., (Editors) (2015).Contraceptive Technology (20th Revised ed.). p. 147-191. Atlanta , GA: Ardent Media, Inc
2. **http://womenshealthcareclinic.com/medical-protocol.html** (retrieved 8/16)
3. Centers for Disease Control and Prevention (CDC). U.S. Selected Practice Recommendations for Contraceptive Use (2016).